The Public Health Nurse As Coordinator in a Geriatric Clinic

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THE GOAL of the geriatric clinic of the San Francisco Regional Office of the Veterans Administration is to help the patient and prevent the necessity of hospitalization or institutional care as long as possible.

The clinic's patients are veterans of the Spanish-American War. Under Public Law 791, 81st Congress, they are eligible to receive medical supervision and appropriate coordinated services. These men, whose median age is 79 years, challenge the clinic to give them more years to live. Confronting geriatrics in the future are the veterans of World War I, whose median age is 66 years. This group does not have the blanket type of outpatient medical care plan provided for the older veterans.

The clinic, opened in 1952, was the first of its kind in the Veterans Administration. The pilot study report, "Coordinated Approach to Geriatrics," is also the first recorded attempt to demonstrate a team approach to geriatrics in a regional office of the Veterans Administration (*1*). The clinic provides facilities and therapeutic accommodations in medicine, public health nursing, physical therapy, nutrition, social service, and psychiatry. Its personnel collaborate with staff specialists, consultants of the regional office, and regular visiting consultants from the local medical society, and with community agencies to give the veteran the care he requires.

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The complications of illnesses, disabilities, and personal and social difficulties of the Spanish-American War veteran are often multiple. To help him with these, the geriatric clinic has a team of specialists consisting of the chief of the clinic, public health nurse, social service worker, physical therapist, psychiatric consultant, and medical secretary.

Clinic sessions are held each Tuesday from 9 to 11:30 a.m. The physical setting includes a clinic room used for other clinics at other times, a waiting room which seats 10 patients, the office of the public health nurse, an emergency bedroom, a surgical unit, and a central supply unit.

Prior to his initial visit to the clinic, the patient has been given a complete physical examination by the staff geriatric consultant, and medical and laboratory records are ready for review. At the clinic the new patient is first interviewed by the public health nurse, whose previous hospital experience and education in public health have prepared her to act as counselor to the patient and coordinator of the clinic's services.

She takes the patient's blood pressure, pulse, and weight, recording them as well as other pertinent information that will be valuable to the geriatric team. But perhaps her most important job in this 20-minute interview is to communicate the clinic's approach to the patient and determine his attitude toward accepting treatment and instruction.

She may notice that the patient is neatly dressed and well groomed, that he appreciates

a comment on his appearance, that he exhibits some stiffness of joints as he seats himself, and that he wears glasses and dentures. But she is also aware that he is a person, with varying physical and mental abilities, needs, feelings, attitudes, and capacities.

Past experience has taught the nurse that one of a patient's foremost fears is "what the doctors found or what laboratory findings revealed." Her own behavior in this conversation may either intensify those fears and anxiety or stimulate revelations which may prove pertinent.

Many interviews have taught her that older people love to talk about their experiences and sometimes it is difficult to focus their attention on a question long enough to get a direct answer. Often, patience and tact are necessary to recall the patient to the original question, although permitting the patient to ventilate his emotions has a therapeutic value.

The nurse's goal in the first interview is to present to the clinic team a profile of the patient's immediate medical problems and his economic, social, and cultural background, and to explain to the patient the various services of the clinic and the regional office. On the patient's first visit she will merely outline these services. At subsequent interviews and referrals to other medical and nursing services, she will devote more time to clarifying the scope of services, utilizing visual aids and emphasizing health measures. After the interview the patient is escorted to the waiting room to be called later to the clinic room.

The nurse then joins the team in the clinic room and listens to the medical review of the patient presented by the staff geriatric consultant, the chief of the clinic. The anecdotal record of the nurse-patient interview is also read. After evaluation of both reports, the patient is escorted into the clinic room and introduced to the staff. The chief of the clinic explains the team approach to the patient and its significance to his health and welfare. The patient is then given a future appointment for medical supervision, and arrangements are mapped out for the integrated services of the team according to the chief of clinic's recommendations. Clinic visits are usually 4 to 5 weeks apart. Approximately 10–12 patients attend each weekly session of the clinic.

The nurse has a short conference with the patient after he has left the clinic room to ascertain his reaction to this type of medical care and to be sure he understands the medical orders. Occasionally she finds he has already been prepared for the clinic by his friends in the waiting room or has heard about it from his comrades in the Spanish-American War veterans organization. A majority of those veterans hold office or attend meetings of the various camp units along the California coast.

The nursing assistants of the regional office are unofficial members of the geriatric team, but they assist in many ways. The male nursing assistant, under medical and nursing supervision, gives direct service to the patient in minor surgery, genitourinary treatment, proctoscopic examinations, and orthopedic steroid therapy. He prepares the patient and the instruments for these treatments, and, before a physical examination, helps a patient who may have difficulty in undressing. The nursing assistants help not only in the geriatric clinic but in other specialized clinics and in the general medicine practiced in the regional office.

Services Within the Regional Office

As counselor and coordinator, the nurse explains the medical program of the regional office and other services of the Veterans Administration to the patient during subsequent visits. The patient may have been referred by the chief of the clinic to have his eyes examined, his hearing tested, or his dentures examined. The nurse is aware of the importance of prosthetics and sensory aids to these patients. For example, when she noticed a significant drop in the weight of one patient, he confided to her that his dentures were loose, and he only wore them during his clinic visit. He had been eating baby food for the past few months. This information was brought to the attention of the clinic physician who referred the patient to the dental clinic.

The mental hygiene unit of the regional office provides a psychiatrist who conducts group therapy for the geriatric clinic patients. A social worker acts as co-leader. The patients

meet informally with the psychiatrist before the clinic sessions begin.

Responses to the group therapy vary. The patients are remarkably self-reliant and reticent in discussing their difficulties before a group. Usually the discussions center around the trials inherent in caring for their aging wives or about their difficulties in adjusting to being a secondary member of someone else's household. When they talk about themselves, they are surprised and relieved to realize they have so much in common with others.

Many surgical services are available to the patients of the geriatric clinic, and surgery can be scheduled at the mutual convenience of patient and surgeon. The surgeon on the staff is qualified in general, plastic, hand, genitourinary, proctological, and orthopedic fields. In general, hand, and plastic surgery, biopsy and diagnostic procedures can be performed. Diagnostic proctological procedures such as sigmoidoscopy, biopsy, treatment of thrombosis, and external anal afflictions, and genitourinary procedures such as care and followup of external urinary fistulae, soundings, and strictural dilations are done in the surgical clinic. In orthopedics, controlled steroid injection therapy is administered to multiple joints.

Since discontinuance of the nutrition service in 1955, the clinic nurse has assumed the responsibility, with the cooperation of the chief of the clinic, of revaluating diets at appropriate intervals. Each diet is modified to conform to changing medical requirements and to the patient's tolerance for certain foods.

Other services are available to the patient in such special fields as allergy, dermatology, arthritis, urology, tuberculosis, diabetes, orthopedics, prosthetics, and sensory aids. Special needs are determined by the chief of the clinic and appropriate referrals are made.

Extramural Services

The hometown medical care program of the Veterans Administration is the extramural service for patients of the geriatric clinic and for eligible veterans of the two World Wars and the Korean conflict who are unable to travel to the regional office or who may require emergency care. In fiscal year 1956, more than 554,000 VA patients received hometown medical care at a cost of $6,290,133. Of this amount, $699,735 was spent to care for 62,769 veterans of the Spanish-American War (*2*).

All geriatric clinic patients, and especially those with a history of heart disease, are informed about the hometown medical care program. The nurse explains the communication necessary between the physician in the patient's community and the authorization officer in the regional office. The patient is also reminded to make his immediate family aware of the program so that they can act in an emergency. The assurance that medical services can be provided in their homes is important to these patients. As they grow older, their homes are more important to them and severance of ties with them are often traumatic.

In an emergency, communication between the authorized fee-basis physician (usually the family physician) attending the patient at home and the chief of clinic may provide the fee-basis physician with the current medical diagnosis, history of illness, and results of laboratory tests, and thus prevent expensive, repetitive tests and examinations.

Fee-basis physicians are usually selected by the patient, and in most instances are the family physician. If the patient does not have his own physician, the Veterans Administration provides him with a list of three in his community, and he selects one of these. At the present time the selection of physicians is limited to those who are members of the California Physicians Service.

Community home nursing services are an important component of the hometown medical care program. The regional office, which has contracts with various community health agencies, can arrange for home visits by members of a visiting nurse association. If there is no such agency in the area where the patient lives, visits by a registered nurse or a licensed vocational nurse can be arranged.

The clinic, the hospital, or the authorized fee-basis physician may indicate the need for home nursing services. The referral for such services, made by the chief of the clinic, may be for the purpose of administering special medication intramuscularly or for followup of prescribed treatment that has been demonstrated to the patient by the clinic nurse. If

home care is needed following a hospital stay, the ward nurse usually explains the home nursing care that is available. Final arrangements for home visits are the responsibility of the chief of the nursing unit of the regional office, who is familiar with the resources of the neighboring communities. Fee-basis physicians' requests for home nursing service go to the chief of the nursing unit of the regional office.

The following case report illustrates the importance of continuity of medical and nursing care in the home.

Mr. W., 83 years of age, had been attending the geriatric clinic for about 5 years. In November 1956 he complained of chest pains and a "loose cough." His established diagnosis was arteriosclerosis and hypertension. An X-ray revealed a mass in the right side of his chest. He was referred to the nearest Veterans Administration hospital for further studies, and the final diagnosis was pulmonary metastasis, primary, undetermined. The hospital physician explained to Mr. W.'s wife and daughter that further treatment was impossible because of the patient's age and the possible complications.

After Mr. W. was discharged from the hospital, the family physician requested weekly home nursing visits for general bedside care, intramuscular injections, and health guidance to the family. Mr. W.'s wife, 80 years of age, and unmarried daughter, 50, who supported the family financially and did the housekeeping as well, were eager to have supportive care.

The chief of the nursing unit contacted the visiting nurse service by telephone, and home nursing care for Mr. W. was started within an hour. The visiting nurse reported to the regional office that the wife and daughter had received her warmly. She had instructed them in maintenance therapy to prevent decubiti, joint stiffness, and loss of self-care ability and pointed out the importance of keeping medicine beyond Mr. W.'s reach, for he became confused at times.

She reported the family had missed Mr. W. when he was hospitalized, were happy to have him at home, and felt they could care for him with a little help from her. Mr. W. stated he would soon recover since he was at home. The visiting nurse association submits a monthly bill of $16, and the fee-basis physician's home services cost $24 a month. Each visits Mr. W. four times a month.

This case demonstrates the teamwork of the hospital, family, fee-basis physician, the community service agency, and the staff of the regional office in the extramural medical treatment program of the Veterans Administration. The visiting nurse is in close contact not only with the attending physician but with the chief of nursing unit in the regional office. Medical orders, prescribed treatment, health instruction to the family, evaluation visits, determination of the number of visits, and environmental factors are discussed with the chief of the nursing unit at intervals.

From the patient's standpoint, the success of the home nursing care is measured by the satisfaction he derives from it. About one-fourth of the cases on record in the regional office are those of Spanish-American War veterans. Periodic telephone calls to patients have assured the office that they are satisfied with the home nursing service.

Dr. E. M. Bluestone has said that when we permit a patient who has reached the terminal stages of his illness, and who still enjoys illusions of hope, to be maintained in familiar surroundings where he can be cared for by himself and his family, we are moving in the right direction in extramural service (*3*).

In fiscal year 1954, 932 patients throughout the VA received home nursing care at a total cost of $88,001.82. The average cost per visit was $2.58, which was considerably below that required to maintain a patient in a general medical and surgical hospital during that fiscal year. Average hospital cost for this period was $19.84 per day (*4*).

The number of patients who receive community nursing service has increased since the program was organized. According to a report in *Nursing Outlook* (*5*), "The monetary value of home nursing services cannot be estimated in terms of the individual veteran's and the community's health and happiness. The average fee per visit was $2.67 in 1955, which is an increase of 9 cents over the 1954 and 18 cents over the 1952 cost per visit. The Government paid a total of $96,251 to contracting public health agencies in the fiscal year 1955 for

their services under the community nursing program. This was an increase of $8,251 over the 1954 cost to the Government and is evidence of the increased use of the home nursing service. But this represents an important reduction in the cost to taxpayers when compared with the cost of the hospital care that would be required."

Volunteer Service

The San Francisco regional office has an active volunteer service of 35 members who represent various organizations. Two volunteers are from the auxiliary unit of the United Spanish War Veterans. The geriatric clinic patients know them both as widows of men who have been active in camp affairs. They package gauze abdominal pads, applicators, and other requested materials, meeting a quota of 3,000 packages a month which are sent to eligible veterans.

They assist in other ways. For example, recently the colonel, a 94-year-old veteran who lives alone in a single room, seemed to be getting weaker by the day and was confused at times. He had an ambivalent feeling about going to the California State veterans home and had twice canceled plans to go there. Each afternoon for 3 weeks he hobbled eight blocks to the regional office and reported to the emergency bedroom to rest and eat the milk and crackers the volunteers served him.

Concerned about him, one of the volunteers contacted his friends in the camp and explained the colonel's predicament. When the camp members visited him, he said he wanted to go to the veterans home, but was worried about his thousand pounds of baggage. The members assured him they would take care of his belongings. Although the physician, nurse, and social worker had tried before to arrange domiciliary care, the colonel was not ready to move until the camp members, alerted by the volunteer, took action.

Two of the volunteers are men. One has charge of the storage and distribution of various health pamphlets to racks throughout the building. The other, a retired pharmacist, gives his time in the pharmacy packaging stock medicines which are sent by mail to veterans whose physicians have requested the medicine.

The regional office has found that volunteer duty is a useful form of rehabilitation in geriatrics and should be encouraged. Assigning a volunteer a definite responsibility and making sure he knows that others are depending on him gives him satisfaction in his work.

Conclusions

The experiences of the public health nurse in the geriatric clinic have been rewarding. She uses skills in health education, teaching, interpreting physicians' orders, and planning with the patient.

She understands that the patient of advanced age has many needs. Indirectly she has shared many of the problems of these patients and has tried to give them guidance. She has learned that they wish to remain independent and assume responsibilities, despite physical and social stresses.

She has learned how these veterans acquire hobbies to compensate for lonely hours, and how they fulfill social needs in the camps of the Spanish-American veterans' organization.

The clinic provides an insight into the geriatrics of the future. The Spanish-American War veteran has challenged the clinic to give him more years to live. The World War I veteran, on the periphery of geriatrics, presents a similar challenge.

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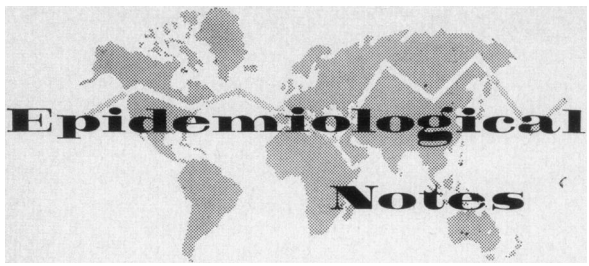

Plastic Film Hazard

Filmy plastic bags, used by dry cleaners and food packagers, were brought to public attention as a household hazard when Dr. James F. Benedict of Erie County, N.Y., was quoted in the *New York Times,* August 29, 1958. He referred to two infants suffocated by such wrappers.

At the October 1958 meeting of the National Safety Council, a delegate issued a warning and mentioned an accidental suffocation said to have been caused by a plastic bag. Four more deaths were cited by Dr. Paul B. Jarrett, chairman of the Maricopa County Medical Society Accident Prevention Committee, in the *Arizona Republic* of January 4, 1959. All of these were infant deaths occurring in the vicinity of Phoenix. Later in January, Dr. A. B. Rosenfield of the Minnesota Department of Health reported to the press that two infants had been suffocated by makeshift pillow covers made from plastic bags.

The use of the bags as covering for bedding appears to have been a contributing factor in many of these infant suffocations. In other cases, babies have managed to grasp plastic bags lying nearby. Suffocation occurs when the limp film clings to the mouth and nostrils. Even toddlers, playing with this thin plastic, have become enmeshed in it and suffocated themselves. The increase in such deaths corresponds with the rise in sales of thin plastic bags. The dry cleaning industry alone bought 600 million in 1958 but almost none in 1955.

In early February 1959, a letter directing attention to the Arizona report was circulated in the medical and health field by Dr. B. H. Conley, secretary of the Commission on Toxicology, American Medical Association. On February 26, the Public Health Service began investigation by requesting its regional offices to seek further information on incidents of this nature through State health departments.

During March, April, and May, reports of more accidental suffocations appeared in quick succession. Additional cautionary statements were issued by health agencies, officials of local medical societies, the National Institute of Dry Cleaning, and the Society of the Plastics Industry. Following the suffocation of a 10-week-old infant in Windsor, Ontario, the Canadian Press reported May 24 to the *New York Times* that the dry cleaning concern affected is abandoning the use of plastic wrappers.

A telegraphic survey of State health officers by the National Safety Council on April 20 brought to light at least 20 accidental suffocations since January 1, 1959, which were reported on the death certificates as due to some sort of plastic film. By the end of May the list of such tragedies had grown to 35 for 1959, according to information received by the Accident Prevention Branch of the Public Health Service. At that time, the known count for 1958 and 1959 was 55 accidental suffocations and 3 suicides reported to have involved plastic film.

The Public Health Service began epidemiological investigation of deaths reported from this cause early in May with the cooperation of State and local health departments. Results of intensive study of seven of these deaths have convinced Service officials of the need for public education to prevent future tragedies of this kind. A cautionary leaflet, "Plastic Film—Correct Use and Mis-use," prepared in cooperation with public and professional organizations by the Society of the Plastics Industry, is available without charge for distribution through public health agencies.

Despite the apparent involvement of plastic film, it is not clear that mechanical suffocation was the true cause of death in all the instances mentioned for 1958 and 1959. A wholly accurate measure of the death toll from plastic film would have been possible at this time only if all infants who died in circumstances suggesting suffocation from it had been examined postmortem by pathologists. In the past, studies of sudden deaths of infants have demonstrated that a significant proportion of those believed due to mechanical suffocation may have resulted from acute respiratory infections, such as tracheobronchitis and acute interstitial pneumonia. In view of these facts, postmortem examination of infants believed to have died from mechanical suffocation is highly desirable.